



**Immediately notify
DOH Communicable
Disease Epidemiology
Phone: 877-539-4344**

Paralytic Shellfish Poisoning

County _____

LHJ Use ID _____
☐ Reported to DOH Date ____/____/____
LHJ Classification ☐ Confirmed
☐ Probable
By: ☐ Lab ☐ Clinical
☐ Epi Link: _____

☐ Outbreak-related

LHJ Cluster# _____
LHJ Cluster
Name: _____

DOH Outbreak # _____

REPORT SOURCE

LHJ notification date ____/____/____

Reporter (check all that apply)

☐ Lab ☐ Hospital ☐ HCP

☐ Public health agency ☐ Other

OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation
start date:
____/____/____

Reporter name _____

Reporter phone _____

Primary HCP name _____

Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____

Address _____ ☐ Homeless

City/State/Zip _____

Phone(s)/Email _____

Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____

Zip code (school or occupation): _____ Phone: _____

Occupation/grade _____

Employer/worksite _____ School/child care name _____

Birth date ____/____/____ Age ____

Gender ☐ F ☐ M ☐ Other ☐ Unk

Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (check all that apply)

☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ____/____/____

☐ Derived

Diagnosis date: ____/____/____

Illness duration: ____ days

Signs and Symptoms

Y N DK NA

- ☐ ☐ ☐ ☐ Mouth tingling or numbness
☐ ☐ ☐ ☐ Breathing difficulty or shortness of breath
☐ ☐ ☐ ☐ Weakness
☐ ☐ ☐ ☐ Extremities numb
☐ ☐ ☐ ☐ Swallowing or speech difficulty
☐ ☐ ☐ ☐ Eyelids drooping (ptosis)
☐ ☐ ☐ ☐ Vision blurred or double
☐ ☐ ☐ ☐ Nausea
☐ ☐ ☐ ☐ Vomiting
☐ ☐ ☐ ☐ Diarrhea Maximum # of stools in 24 hours: ____

Clinical Findings

Y N DK NA

- ☐ ☐ ☐ ☐ **Ataxia**
☐ ☐ ☐ ☐ **Cranial nerve abnormalities (bulbar weakness)**
☐ ☐ ☐ ☐ **Paralysis or weakness**
☐ Acute flaccid paralysis ☐ Asymmetric
☐ Symmetric ☐ Ascending ☐ Descending
☐ ☐ ☐ ☐ Respiratory distress
☐ ☐ ☐ ☐ **Respiratory failure**
☐ ☐ ☐ ☐ Confusion
☐ ☐ ☐ ☐ Admitted to intensive care unit
☐ ☐ ☐ ☐ Mechanical ventilation or intubation required during hospitalization

Hospitalization

Y N DK NA

☐ ☐ ☐ ☐ Hospitalized for this illness

Hospital name _____

Admit date ____/____/____ Discharge date ____/____/____

Y N DK NA

☐ ☐ ☐ ☐ Died from illness Death date ____/____/____
☐ ☐ ☐ ☐ Autopsy Place of death _____

Laboratory

P = Positive O = Other
N = Negative NT = Not Tested
I = Indeterminate

Collection date ____/____/____ Source _____

P N I O NT

- ☐ ☐ ☐ ☐ ☐ **High levels of associated dinoflagellates in source water for epidemiologically implicated shellfish**
☐ ☐ ☐ ☐ ☐ **Saxitoxin in epidemiologically implicated food**

NOTES

INFECTION TIMELINE

Enter onset date/time
(first sx) in heavy
box. Count backward
to figure probable
exposure period

Hours from
onset:

Exposure period

- 4 - minutes

o
n
s
e
t

Calendar dates/times:

EXPOSURE (Refer to dates above)

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or
outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Dates/Locations: _____

Y N DK NA

☐ ☐ ☐ ☐ Case knows anyone with similar symptoms
☐ ☐ ☐ ☐ **Epidemiologic link to a confirmed human case**

Y N DK NA

☐ ☐ ☐ ☐ **Shellfish or seafood**

County or location shellfish collected: _____

☐ ☐ ☐ ☐ Known contaminated food product

☐ ☐ ☐ ☐ Food from restaurants

Restaurant name/location: _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

Exposure details: _____

☐ **No risk factors or exposures could be identified**

☐ **Patient could not be interviewed**

PUBLIC HEALTH ISSUES**PUBLIC HEALTH ACTIONS**

- ☐ Notify others sharing exposure
☐ Notify shellfish program
☐ Initiate trace-back investigation
☐ Other, specify: _____

NOTES

Investigator _____

Investigation complete date ____/____/____

Local health jurisdiction _____

Record complete date ____/____/____